



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258

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FINAL MINUTES FOR BOARD OFFSITE PLANNING MEETING Held at 9:30 a.m. on September 23, 2005 9535 E. Doubletree Ranch Road • Scottsdale, Arizona

Board Members

Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin, Sr., M.D.

I. CALL TO ORDER

Timothy B. Hunter, M.D. called the meeting to order at 9:30 a.m.

II. ROLL CALL

The following Board members were present: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D. Robert P. Goldfarb, M.D., Timothy B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine L. Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Paul M. Petelin, M.D.

III. CALL TO PUBLIC

No one was present for Call to Public.

1. Discussion of Agency Processes

Timothy C. Miller, J.D., Executive Director, provided a brief overview of agency processes, including a flowchart outlining the intake and investigation processes. The Board asked for clarification of the process when a complaint is not opened because the Board has no jurisdiction. Mr. Miller explained that complainants are provided a letter informing them of why the case was not opened and are provided the opportunity to provide additional information that would allow the Board to open the case. Under this process the physician is not notified that the case was not opened. Mr. Miller informed the Board that most of these cases are a result of poor bedside manner or rude behavior. Mr. Miller informed the Board that these cases are reviewed by the Chief Medical Consultant and Head of Investigations. The Board agreed that it would be beneficial to inform the physician of the correspondence by copying the physician on the letter to the complainant. If an anonymous complaint is filed the anonymity of the complainant should be preserved. Hopefully, the letter will allow the physician to correct the purpose of this letter

Mr. Miller explained the process for fast track cases. The Intake Officer identifies these cases immediately and notifies the Executive Director, Deputy Executive Director, Chief Medical Consultant, Investigations Manager, and Board Legal Counsel. Mark Nanney, M.D., Chief Medical Consultant, is also available to assist investigators to identify high priority cases.

Mr. Miller explained the process for notifying physicians of opened cases and the statutory violations. He also explained that the process has been revised so that the complaint is not posted to the Board's website until the

physician has been noticed. Christine Cassetta, Board Legal Counsel, stated that she and Mr. Miller are working together to interpret the statutory requirement for when "pending complaints" should be posted to the website. The question is when the case becomes "pending". Sharon B. Megdal, Ph.D. suggested using the physician's e-mail address, if it is provided on the renewal form, to electronically notify the physician of the open case.

Next, the Board discussed the process for sending cases to outside medical consultants for review. Mr. Miller explained that the agency is currently exploring the idea of posting cases to a secure website that could be accessed by the outside medical consultant. This option is also being considered for materials provided to the Board for its meetings. Patrick N. Connell, M.D. suggested that a security measure be incorporated into the CD.

The Board addressed the issue of last minute evidence being presented to the Board by the physician during the course of a formal interview. Mr. Miller explained the new process provides the physician a second notice of sustained allegations and an opportunity to respond. It is hoped this will cut down on last-minute submissions. The Board agreed that there should be a rule or substantive policy statement to state that the Board will not accept materials submitted within 72 hours of the Board meeting. The Board would not consider materials submitted after this timeframe. The person submitting late materials would have 1-2 minutes to explain the merit of those materials during either the Call to the Public or at the time the case is heard for a Formal Interview.

MOTION: Douglas D. Lee, M.D. moved to direct staff to adopt a substantive policy statement to not accept materials submitted within 72 hours of the Board meeting.

SECONDED: Ram R. Krishna, M.D.

VOTE: 12-0

Mr. Miller then explained in more detail how the agency would send a final notice to the physician of substantiated allegations and ask the physician to respond to those allegations within 10 days. The Board agreed that this was an improvement to the process. Cathy Riggs, Investigations Manager, explained that the agency is more careful when requesting medical records. Investigators now request specific records pertaining to the issue rather than just issuing broad scope subpoenas.

Mr. Miller discussed the second stage of the regulation process. He provided the composition of the Staff Investigational Review committee (SIRC), the roles of the SIRC members and SIRC's role to develop recommendations. The SIRC report explains the reasoning for the recommendation. Robert P. Goldfarb, M.D. clarified that Dr. Nanney does not review cases as both a medical consultant and a member of SIRC. The Board asked for clarification that non-physician members on SIRC do not overrule a medical consultant's opinion. Dr. Nanney stated that SIRC does not do so and even he, as a physician, cannot do so. The Board also asked that staff not craft their recommendations based on how it thinks the Board would respond, but rather, on what staff believes is best.

Patrick N. Connell, M.D. asked if Board staff has a way of tracking Board actions for certain violations. Bernadette E. Phelan, Ph.D., Assistant Director, stated that current database does not allow for this type of tracking, but the new database that is in the procurement process will be able to track.

Following the discussion of SIRC, the Board discussed the third stage of the regulation process, specifically, offering physicians consent agreements with formal interview notices. Ms. Cassetta explained that the formal interview notice clearly states the physician's options and what each of those options means. Ms. Cassetta agreed to review the formal interview invitation letter to ensure the options are fully explained to physicians.

The Board requested that medical consultants verbally state during their presentations at Board meetings the applicable standard of care, deviation, and patient harm.

Dr. Hunter commended Mr. Miller for developing a thorough process. He stated that he has a better understanding of the process. Mr. Miller stated that this was a staff evolved process that involved input from the Board, managers and Staff. Dr. Megdal stated that the SIRC process now more closely resembles the process the Board originally approved.

MOTION: William Martin, M.D. moved that the Board approves and fully supports the investigation process as developed and presented by the Executive Director and has full confidence that the investigative process is thorough and fair to both physicians and complainants.

SECONDED: Robert P. Goldfarb, M.D.

VOTE: 12-0

2. Physician Health Program

Dr. Hunter explained that the Physician Health Program (PHP) is something the Board has been trying to implement for years and credited Dr. Connell for his work on the program.

Dr. Phelan provided statistics to justify the need for a PHP. In FY 05 there were 14 practice limitations due to medical reasons, 32 interim orders for evaluations, 90 participants in the Monitored Aftercare Program and of those participants 39% are under confidential agreements. Ms. Phelan explained that PHP would be an umbrella program that includes monitoring of physicians with physical, behavioral health and substance abuse problems. There are four positions allocated to the Program and two are currently filled. Dr. Nanney would serve as an in-house medical advisor to the Program. In the future the Program would include a PHP consultant. Dr. Connell questioned whether the agency would accept a single outside vendor to consult with the program. Ms. Phelan stated that staff would prefer to have a single vendor because of the difficulty monitoring physicians with co-occurring disorders. Dr. Connell suggested that when developing the RFP outcome and performance parameters should be included. The scope should also be defined in such a way as to not exclude in-state consultants who may not have experience with a joint substance abuse and physician health program. Dr. Megdal expressed the need for Board members to be involved in the review of solicitations for the program. There should also be a pre-proposal conference to provide vendors in other states time to develop their proposals.

The Board discussed the fact that there is no statutory funding for this program. This is one of the reasons for hiring a single vendor to handle all substance related and non-substance related monitoring.

Ms. Phelan asked the Board for authorization to begin the solicitation process and to use current funding for the program. The current MAP contract ends next June and that is what is driving the need for a solicitation at this time.

Ms. Phelan explained the intake process for PHP cases. There is a confidential and non-confidential track, depending on whether there is a statutory violation and whether the physician is willing to voluntarily enter treatment. Physicians can self-report, PHP issues may be discovered during the investigative process, or hospitals can refer physicians to the Program. Dr. Connell stated that the original intent for the Program was to also provide a mechanism for a healthcare entity to refer a physician to the Program even though there is no violation of the Medical Practice Act. Dr. Connell questioned what the process would be for a physician who has not violated the Medical Practice Act, but who refuses treatment. Mr. Miller stated that if the Chief Medical Consultant identified the need for treatment because of the danger to the public and the physician refused to enter treatment then the case would go to the Board in a public forum if there was an identified statutory issue. One of the reasons for a Program Medical Consultant is to first determine whether there is an issue that would need treatment. If the physician does not present harm to the public and there is no violation of the Medical Practice Act the Board does not have jurisdiction to order the physician into treatment.

Ms. Cassetta provided some case examples for a physician with a DUI arrest and whether the Board would accept the physician into a confidential program or not. Ms. Cassetta explained that a DUI by itself is not a violation of the Medical Practice Act, but failure to timely report the DUI is a violation of the Medical Practice Act requiring compliance with laws applicable to the practice of medicine.

1. DUI not reported or reported late, and physician not impaired – Advisory Letter For Failure to Report
2. DUI not reported or reported late and physician admits impairment – Advisory letter for Failure to Report/SRA for rehabilitation
3. DUI reported on time and physician admits to impairment – SRA
4. DUI reported on time and there is no impairment – ED Dismissal.

Ms. Muller explained that historically, 75% of participants participated in MAP confidentially. Due to an agency policy change in 2003 regarding the definition of self-report that number has dramatically swung the other way. Staff is concerned that there are physicians who need help but who do not come forward because of the probationary approach taken by the agency. Dr. Connell stated that denial is part of the problem with substance abuse and considering national averages for persons with substance abuse problems there should be more physicians in the program. Dr. Connell suggested that a kinder, gentler approach might bring more physicians who are practicing with substance abuse problems into the program and allow the Board to protect the public by knowing about and monitoring these physicians.

Dr. Lee expressed concern about physicians who relapse multiple times. It is the Board's policy that a second relapse would result in a probationary order and a relapse on a probationary order would be the third strike that would lead to revocation.

Motion: Patrick N. Connell, M.D. moved that if a physician does not report a DUI arrest timely, but there is no dependence that the Board continues current practice of bringing the failure to report forward for adjudication.

SECONDED: Robert P. Goldfarb, M.D.

VOTE: 10-2

The Board asked that staff develop a definition of a self-report and bring it back to the Board for consideration.

Ms. Muller informed the Board that physicians participating in MAP confidentially are still required to provide a copy of the agreement to each hospital where that physician has privileges.

MOTION: Robert P. Goldfarb, M.D. moved to approve the PHP concept and the concept of developing the bid process for a single contract. If there are subcontracts Dr. Goldfarb moved that there be high performance expectations of the subcontractors.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-1

Ms. Jordan explained that she voted against the motion because of the concept of an outside contractor.

3. Public Information

Dr. Hunter stated that physicians often call Board staff requesting information regarding the Medical Practice Act, but staff will not provide the information. Ms. Cassetta explained that there are some issues that are and can be addressed on the FAQ section of the Board's website. However, Board staff cannot provide legal advice in responding to more complicated questions. Dr. Megdal agreed and stated that that is not the role of staff, but rather the State and county medical societies.

Mr. Miller also informed the Board of some of the initiatives staff is taking to provide information to the public and physicians via newsletters and press releases. Roger Downey, Public Information Officer, explained his process of creating a good public image through positive press relations.

The Board agreed that the newsletter should not include the names of physicians who have been disciplined, other than suspensions and revocations. Dr. Connell suggested that the newsletter contain educational information such as the reason why discipline was issued. The Board's recent action page is a good resource for directing the public to the Board's action. The newsletter will also include articles that are beneficial to patients and their receipt of healthcare.

4. Communication Between Board and Staff

Dr. Hunter began the discussion by asking what the policy is for a staff person (current or former) who contacts a Board member and whether written communication to a Board member is confidential. Mr. Miller explained that there is no policy prohibiting staff from contacting a Board member about agency concerns. However, that communication may be forwarded back to the agency for review. Ms. Cassetta explained that written communications are a matter of public record and the agency is bound to retain them and produce them upon a public records request. Dr. Megdal asked if the Board is required to turn over communications to the agency or if she is required to keep a file and be prepared to provide it upon request. Ms. Cassetta advised that if the Board members chose to retain the communications without referring them to the agency that they should keep a file that could be reproduced upon request. Several Board members expressed concern with turning over communications sent to them personally to the agency. Dr. Krishna suggested that Board members forward all communications to the Chair. Ms. Cassetta also informed the Board to forward all case-sensitive communications to her or staff so it can be distributed it to the rest of the Board.

4. Discussion of Definition of Doctor-Patient Relationship

Mr. Miller stated that the Board has established that a doctor-patient relationship does not exist with physicians who perform independent medical examinations. However, the establishment of a doctor-patient relationship is not clearly defined in statute. Dr. Connell suggested that either staff research the issue or the Board develop a subcommittee to develop a definition. In current medical practices the lack of a doctor-patient relationship has a direct impact on patient

care. Ms. Cassetta offered to research whether current case law sufficiently addresses the issue or if the Board needs to adopt a definition.

Ms. Jordan also expressed the need for a clear definition as it pertains to telemedicine and Internet prescribing. Ronnie R. Cox, Ph.D. informed the Board of efforts the Federation of State Medical Boards is taking to define doctor-patient relationship as it pertains to Internet prescribing.

5. Information Only Matters

The Board discussed the issue of web-based continuing medical education (CME). Dr. Hunter was supportive of the Board providing CME courses on the Board's website. Ms. Cassetta advised that the Board could implement a voluntary course without a statutory change. Dona Pardo, Ph.D., R.N. stated that the Board could run a pilot program on how long it would take to prepare to take a Board CME test and then grant the number of CME hours accordingly. This would not be Category I CME. At a later date the Board could consider a jurisprudence type examination of licensure.

The Board discussed the timeliness of Board materials and stated that overall they were happy with the timeframes for delivery of the Board CD. The Board asked that staff create a supplemental CD that does not overwrite the notes Board members make on the first CD.

The Board members agreed that hyperlinked investigative reports would be very helpful and time saving. Dr. Lee asked that medical records be presented in a chronological order. Dr. Nanney informed the Board that internal medical consultants are also book marking their reports.

The Board discussed regulation of expert witness testimony. Dr. Goldfarb stated that there are physicians who are paid to testify and who often travel from state to state. The American Neurological Association has censured and expelled physicians who have provided false expert witness testimony. Dr. Goldfarb suggested developing an expert panel to review these types of cases. Ms. Cassetta provided a memo to the Board outlining suggested statutory language related to expert testimony that would provide the Board the ability to adjudicate cases with false expert witness testimony. However, she noted it might be complicated and time and labor intensive for the Board to determine the difference between a falsehood and incorrect testimony that a physician honestly felt to be true. Mr. Miller suggested that the Board consider only taking the complaint from the judge who heard the case.

MOTION: Patrick N. Connell, M.D. moved to direct staff to conduct additional research regarding expert witness testimony.

SECONDED: Robert P. Goldfarb, M.D.

VOTE: 12-0

In conclusion, Mr. Miller thanked the Board for its support.

The meeting adjourned at 4:00 p.m.



Timothy C. Miller, J.D.,
Executive Director